		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035246

Facility Name: HENDERSON COUNTY RETIREMENT CENTER

Address: 604 OAKWOOD DRIVE (Number) STRONGHURST (City) 61480 (Zip Code)

County: HENDERSON

Telephone Number: (309) 924-1123 **Fax #** (309) 924-1926

IDPA ID Number: 3633781611001

Date of Initial License for Current Owners: 06/28/89

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 © 3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JAMES G. HULL **Telephone Number:** (217) 228-1950

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) JAMES G. HULL, V.P.
(Firm Name & Address) WDM COMPUTER SVCS, 1900 HARRISON, QUINCY, IL
(Telephone) (217) 2281950 Fax # (217) 222-6053

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 8/15/01

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	66	22,794	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	66	22,794	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,164	11,235		20,399	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,164	11,235		20,399	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.49%

D. How many bed-hold days during this year were paid by Public Aid?
150 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/28/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/16/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CE # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	113,246	9,446	2,372	125,064		125,064		125,064			1
2	Food Purchase		89,023		89,023		89,023	(408)	88,615			2
3	Housekeeping	48,326	6,242		54,568		54,568		54,568			3
4	Laundry	24,952	8,693	24,901	58,546		58,546		58,546			4
5	Heat and Other Utilities			45,578	45,578		45,578		45,578			5
6	Maintenance	14,968	3,827	68,935	87,730		87,730		87,730			6
7	Other (specify):*											7
8	**TOTAL General Services**	201,492	117,231	141,786	460,509		460,509	(408)	460,101			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	581,542	54,703	300	636,545		636,545	(687)	635,858			10
10a	Therapy	8,200	146	4,228	12,574		12,574		12,574			10a
11	Activities	42,992	6,091	1,620	50,703		50,703		50,703			11
12	Social Services	33,487	2,901	1,620	38,008		38,008		38,008			12
13	Nurse Aide Training	2,352	582	2,167	5,101		5,101		5,101			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	668,573	64,423	21,935	754,931		754,931	(687)	754,244			16
	C. General Administration											
17	Administrative	41,196			41,196		41,196		41,196			17
18	Directors Fees											18
19	Professional Services			21,304	21,304		21,304		21,304			19
20	Dues, Fees, Subscriptions & Promotions			14,944	14,944	(100)	14,844	(4,431)	10,413			20
21	Clerical & General Office Expenses	42,381	6,366	7,414	56,161		56,161		56,161			21
22	Employee Benefits & Payroll Taxes			171,004	171,004		171,004		171,004			22
23	Inservice Training & Education			1,891	1,891	(548)	1,343		1,343			23
24	Travel and Seminar			2,102	2,102	548	2,650		2,650			24
25	Other Admin. Staff Transportation		2,579		2,579		2,579		2,579			25
26	Insurance-Prop.Liab.Malpractice			14,936	14,936		14,936		14,936			26
27	Other (specify):*					100	100	(100)				27
28	**TOTAL General Administration**	83,577	8,945	233,595	326,117		326,117	(4,531)	321,586			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	953,642	190,599	397,316	1,541,557		1,541,557	(5,626)	1,535,931			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER #0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			112,517	112,517		112,517	(12,219)	100,298			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			96,349	96,349		96,349	(24,140)	72,209			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,690	1,690		1,690		1,690			35
36	Other (specify):*											36
37	**TOTAL Ownership**			210,556	210,556		210,556	(36,359)	174,197			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			13,735	13,735		13,735		13,735			40
41	Coffee and Gift Shops		3,298		3,298		3,298		3,298			41
42	Provider Participation Fee			34,191	34,191		34,191		34,191			42
43	Other (specify):*			222	222		222	(222)				43
44	**TOTAL Special Cost Centers**		3,298	48,148	51,446		51,446	(222)	51,224			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	953,642	193,897	656,020	1,803,559		1,803,559	(42,207)	1,761,352			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (687)	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(408)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(223)	30		9
10	Interest and Other Investment Income	(24,140)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(100)	27		18
19	Entertainment				19
20	Contributions	(222)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,431)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Lease Buy-out Deprec	(11,996)	30		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (42,207)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (42,207)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
HENDERSON COUNTY RETIREMENT CENTER

ID# 0035246
Report Period Beginning: 01/01/00
Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lease Buy-out Deprec	$ (11,996)	30	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
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36				36
37				37
38				38
39				39
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41				41
42				42
43				43
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67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(11,996)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER # 0035246 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(408)	0	0	0	0	0	0	0	0	0	0	(408)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(408)	0	0	0	0	0	0	0	0	0	0	(408)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(687)	0	0	0	0	0	0	0	0	0	0	(687)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(687)	0	0	0	0	0	0	0	0	0	0	(687)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,431)	0	0	0	0	0	0	0	0	0	0	(4,431)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(100)	0	0	0	0	0	0	0	0	0	0	(100)	27
28	**TOTAL General Administration**	(4,531)	0	0	0	0	0	0	0	0	0	0	(4,531)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,626)	0	0	0	0	0	0	0	0	0	0	(5,626)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER # 0035246 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(12,219)	0	0	0	0	0	0	0	0	0	0	(12,219)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(24,140)	0	0	0	0	0	0	0	0	0	0	(24,140)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(36,359)	0	0	0	0	0	0	0	0	0	0	(36,359)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(222)	0	0	0	0	0	0	0	0	0	0	(222)	43
44	**TOTAL Special Cost Centers**	(222)	0	0	0	0	0	0	0	0	0	0	(222)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(42,207)	0	0	0	0	0	0	0	0	0	0	(42,207)	45

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HENDERSON COUNTY RETIREMENT C # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CE # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	SECURITY SAVINGS & LOAN		X	MORTGAGE	$11,137.00	04/01/93	$ 2,000,000	$ 1,144,790	07/01/18		$ 94,632	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK OF STRONGHURST		X	CASH FLOW		0	VARIOUS	65,000		VARIOUS	1,717	6
7												7
8												8
9	TOTAL Facility Related				$11,137.00		$ 2,000,000	$ 1,209,790			$ 96,349	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,000,000	$ 1,209,790			$ 96,349	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER **#** 0035246 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,636 B. General Construction Type: Exterior BRICK Frame WOOD-STELL Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	CARE RELATED	217,600	1988	$ 15,000	1
2					2
3	TOTALS	217,600		$ 15,000	3

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1989	1988	$ 1,260,000	$ 42,031	30	$ 41,872	$ (159)	$ 485,922	4
5	6		2000	2000	505,989	5,281	40	5,281		5,281	5
6											6
7											7
8											8
	Improvement Type**										
9	PARKING LOT/LANDSCAPING			1989	25,102	1,258	20	1,249	(9)	14,276	9
10	LANDSCAPING			1990	937	47	20	47		480	10
11	LAND IMPROVEMENT			1995	1,839	92	20	92		537	11
12	BRICK SIGN			1996	12,915	620	12	646	26	3,196	12
13	LAND IMPROVEMENT			1992	2,003	101	20	100	(1)	812	13
14	LIGHTNING RODS			1998	3,600	240	15	240		620	14
15	NEW SOFFITS			1998	26,138	1,752	15	1,743	(9)	4,381	15
16	PHONE SYSTEM			1998	6,738	449	15	449		1,085	16
17	SIDE WALKS			1998	4,500	226	20	225	(1)	490	17
18	ALARM SYSTEM			1998	8,266	834	10	827	(7)	1,806	18
19	LAUNDRY/GARAGE BLDG			1999	50,330	3,374	15	3,355	(19)	4,499	19
20	STORAGE BLDG			1999	8,911	597	15	594	(3)	796	20
21	NEW ROOF			1999	16,311	1,094	15	1,087	(7)	1,185	21
22	LANDSCAPING			2000	1,706	14	20	14		14	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,935,285	$ 58,010		$ 57,821	$ (189)	$ 525,380	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTI# 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 40,092	$ 1,926	$ 1,926	$	9	$ 1,926	37
38	Current Year Purchases	460,890	37,451	37,451		9	308,477	38
39	Fully Depreciated Assets	40,589				9	40,589	39
40								40
41	TOTALS	$ 541,571	$ 39,377	$ 39,377	$		$ 350,992	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	CARE RELATED	85 F-350 V	1996	$ 7,500	$ 1,534	$ 1,500	$ (34)	5	$ 7,117	42
43	CARE RELATED	VAN	1998	8,000	1,600	1,600		5	3,600	43
44										44
45										45
46	TOTALS			$ 15,500	$ 3,134	$ 3,100	$ (34)		$ 10,717	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,507,356	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 100,521	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 100,298	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (223)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 887,089	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 1,690 Description: OXYGEN CONCENTRATORS
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 1,726	$	$ 1,726
2	Books and Supplies			582		582
3	Classroom Wages	(a)		2,131		2,131
4	Clinical Wages	(b)		221		221
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			441		441
9	TOTALS		$	$ 5,101	$	$ 5,101
10	SUM OF line 9, col. 1 and 2	(e)	$ 5,101			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER # 0035246 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 68,558	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	210,580		3
4	Supply Inventory (priced at FIFO)	9,386		4
5	Short-Term Investments	255,540		5
6	Prepaid Insurance	3,512		6
7	Other Prepaid Expenses	704		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 548,280	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,500		13
14	Buildings, at Historical Cost	2,308,219		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	560,864		16
17	Accumulated Depreciation (book methods)	(979,901)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe BOND	1,000		22
23	Other(specify): C-I-P	884		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,913,566	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,461,846	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 26,256	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	65,000		29
30	Accrued Salaries Payable	40,891		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	7,974		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 140,121	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,144,790		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,144,790	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,284,911	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,176,935	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,461,846	$	48

***(See instructions.)**

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,246,084	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	2,790	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,248,874	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(71,939)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (71,939)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,176,935	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTEI # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,683,770	1
2	Discounts and Allowances for all Levels	(1,089)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,682,681	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	687	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 687	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,285	12
13	Barber and Beauty Care	13,115	13
14	Non-Patient Meals	408	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 16,808	23
	D. Non-Operating Revenue		
24	Contributions	5,425	24
25	Interest and Other Investment Income***	24,140	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 29,565	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DUES	725	28
28a	MISCELLANEOUS INCOME	1,154	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,879	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,731,620	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	460,509	31
32	Health Care	754,931	32
33	General Administration	326,117	33
	B. Capital Expense		
34	Ownership	210,556	34
	C. Ancillary Expense		
35	Special Cost Centers	17,255	35
36	Provider Participation Fee	34,191	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,803,559	40
41	**Income before Income Taxes (line 30 minus line 40)****	(71,939)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (71,939)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Yes **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,032	2,088	$ 37,591	$ 18.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,528	4,971	76,874	15.46	3
4	Licensed Practical Nurses	15,613	17,059	201,295	11.80	4
5	Nurse Aides & Orderlies	33,008	35,419	268,134	7.57	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	904	1,032	8,200	7.95	8
9	Activity Director	1,880	2,088	19,112	9.15	9
10	Activity Assistants	3,741	3,843	23,880	6.21	10
11	Social Service Workers	3,412	3,781	33,487	8.86	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,906	2,057	17,890	8.70	14
15	Cook Helpers/Assistants	5,358	5,826	37,576	6.45	15
16	Dishwashers	8,810	9,733	57,780	5.94	16
17	Maintenance Workers	1,603	1,830	14,968	8.18	17
18	Housekeepers	7,860	8,264	48,326	5.85	18
19	Laundry	2,822	3,085	24,952	8.09	19
20	Administrator	2,016	2,168	41,196	19.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,514	4,922	42,381	8.61	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	100,007	108,166	$ 953,642 *	$ 8.82	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Contract	$ 2,373	1-3	35
36	Medical Director	Contract	12,000	9-3	36
37	Medical Records Consultant	12	300	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	290	4,228	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,620	11-3	44
45	Social Service Consultant	24	1,620	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	350	$ 22,141		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTI # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RICHARD CLIFTON	ADMINISTRATOR	0	$ 41,196
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 41,196

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
WDM COMPUTER SERVICES	ACCOUNTING	$ 15,796
FORT & NEFF	LEGAL	50
DORAN INSURANCE	INS. ADMINISTRATION	3,500
BARASH STOERZBACH	LEGAL	1,958
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 21,304

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,529
Unemployment Compensation Insurance	
FICA Taxes	72,344
Employee Health Insurance	69,559
Employee Meals	666
Illinois Municipal Retirement Fund (IMRF)*	
UNIFORMS	906
TOTAL (agree to Schedule V, line 22, col.8)	$ 171,004

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,142
Health Care Worker Background Check	264
(Indicate # of checks performed 22)	
SUBSCRIPTIONS	156
LSN MEMBERSHIP	2,231
LTCNA DUES	35
ACTIVITY DIR FEE	98
PUB. REL./ADVERTISING	4,431
MISC DUES/MEMBERSHIPS	487
Less: Public Relations Expense	(2,535)
Non-allowable advertising	(1,896)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,413

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
SEE ATTATCHED LIST	2,650
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,650

**See instructions.

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HENDERSON COUNTY RETIREMENT CENTER # 0035246 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **2231**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **14**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,329** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **34,191**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **665** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **408**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **90%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Henderson County Retirement Center, Inc.
#0035246

Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	$476.00
REPAIRS & MAINT BUILDING	$8,790.00
REPAIRS & MAINT EQUIP	$5,295.00
REPAIRS & MAINT GROUNDS	$240.00
REPAIRS & MAINT LAUNDRY	$329.00
REPAIRS & MAINT HSK	$1,322.00
REPAIRS & MAINT ALARM	$1,179.00
OUTSIDE SERVICES	$44,230.00
COMPUTER NETWORK SUPPORT	$2,884.00
REFUSE	$2,400.00
EXTERMITATOR	$1,001.00
Equipment rental	$789.00
TOTAL	$68,935.00

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	$7,414.00
TOTAL	$7,414.00

Schedule V. Line 25, Column 2

Auto Exp. & Service	$1,041.00
Auto Gas & Oil	$695.00
Business Mileage Expense	$843.00
	$2,579.00

Schedule V. Line 27, Column 6

Late fine (Il Charity Bureau Fund)	$100.00

Schedule V. Line 43, Column3

Charitable Contributions	$222.00

Schedule V. Line 23,24,20,27, Column 5
Reclassifications

Reclassify $547.67 out of in-service training and into seminars.

$495.00 registration fee for LSN Seminar.
$52.67 Mileage to Il Healthcare Conference

Reclassify $100.00 late fine out of licenses and into other admin.

Schedule XX. Question 12

The following employees work in multiple departments.

1. Amanda Muhleman works in dietary and activities.
2. Debbie Sells works in dietary and as an aid in nursing.

Henderson County Retirement Center, Inc.
#0035246

Schedule V, Line 24 Column 3

Date	Seminar	Location	Who Attended	Regist.	Mileage	Meals	Hotel	Total
3/8	Continuing Education		Joyce Bass		$95.68			$95.68
3/22	Food Show		Joyce Bass		$29.92			$29.92
4/28	MDS Correction Policy	Peoria,IL	Carol Johnson Darlene Fox	######	$44.85			$174.85
4/4	Food Show		Joyce Bass		$70.38			$70.38
7/7	MDS 2.0 Advanced	Springfield,IL	Karen Jacobs Carol Johnson	######	$75.74			$215.74
8/8 & 8/10	IHCA Convention & Trade Show	Springfield,IL	Richard Clifton Karen Jacobs Carol Johnson Joyce Bass Jennifer Schaley Mary Lillard Nancy Shadle Carol Dillon Judy Avery Diana Isaacson	######				$625.00
10/12	2000 Il Nursing Law	Peoria,IL	Carol Johnson Karen Jacobs	$98.00	$40.98	$8.00		$146.98
9/19	Train the Trainer	Galesburg,IL	Karen Jocobs Carol Johnson	######				$200.00
10/3 & 10/4	LSN Convention		Joyce Bass Carol Dillon Jennifer Schaley Karen Jacobs	######	$77.28		$217.80	$790.08
9/11 - 9/13	Il Healthcare Conference	Springfield,IL	Carol Johnson Karen Jacobs Jennifer Schaley		$170.01			$170.01
	Dietary test		Joyce Bass		$97.06		$33.61	$130.67
		Total						$2,649.31

Henderson County Retirement Center, Inc.
#0035246
Board Members

Diana Doran, Pres 2002
Box 417
Carman, IL 61425

Kathy Symmonds, V.Pres. 2002
Box 202
Stronghurst, IL 61480

John Allaman, Treas. 2001
RR 1
Kirkwood, IL 61447

Nancy Stevenson, Sec. 2002
RR 1
Gladstone, IL 61437

Ralph Tatge, 2001
RR 1
Stronghurst, IL 61480

Mary Reed, 2001
RR 1, Box 80
Little York, IL 61453

Bill Steck, 2003
RR 1
Carman, IL 61425

Tom Edmonds, 2003
RR 1, Box 129
Lomax, IL 61454

Tony Griepentrog, 2003
RR 1
Stronghurst, IL 61480

<u>Honorary Board Members</u>
Laura Kent Donahue
Zach Stamp

* Diana Doran provides employee insuance through Doran Insurance.

HENDERSON COUNTY RETIREMENT CENTER, INC.
NEW CONSTRUCTION WORKSHEET
#0035246

Vendor	Invoice	new addition	garage $	storage building
MIDWEST DESIGN	retainer	$2,750.00		
SHK3 ARCHITECHNICS	fees	$3,347.00		
SHK3 ARCHITECHNICS	fees	$6,695.00		
IL DEPT OF PUBLIC HEALTH	plan review	$5,574.00		
SHK3 ARCHITECHNICS	fees	$11,750.00		
TATE CONSTRUCTION	garage & storage bldg		$12,000.00	
TATE CONSTRUCTION	garage & storage bldg		$15,000.00	
TATE CONSTRUCTION	garage & storage bldg		$32,241.00	
DAVIS CONSTRUCTION	contract	$66,500.00		
SHK3 ARCHITECHNICS	fees	$1,211.00		
D&D CONSTRUCTION	contract	$15,987.00		
DAVIS CONSTRUCTION	contract	$95,475.00		
DAVIS CONSTRUCTION	contract	$44,237.50		
DAVIS CONSTRUCTION	contract	$87,500.00		
BARASH & STOERZBACH	legal	$748.75		
STRONGHURST IMP.	misc bldg materials	$88.66		
FRANK MILLARD & CO	magnetic doors	$144.00		
FRANK MILLARD & CO	temp elec. furnaces	$480.00		
DAVIS CONSTRUCTION	contract	$67,700.00		
FOX TIRE SERVICE	misc bldg materials	$98.81		
BARASH & STOERZBACH	legal	$669.21		
GETZ FIRE EQUIPMENT	wire smoke detectors	$354.02		
TATE CONSTRUCTION	sinks and faucets	$1,074.67		
LUANNA JOHNSON	wallpaper labor	$2,203.31		
MYNATT CONSTRUCTION	labor	$1,937.50		
LUANNA JOHNSON	painting & papering labor	$1,100.34		
FLOOR CRAFTERS	flooring	$11,731.56		
VILLAGE OF STRONGHURST	meter hookup	$410.73		
D.C. COOPER CORP	railings w/labor	$2,500.00		
THOMPSON ELECTRONICS	labor	$2,146.65		
BARASH & STOERZBACH	Legal	$565.00		
JACKSON DISPOSAL	disposal of waste	$100.00		
LUANNA JOHNSON	painting labor	$252.00		
LUANNA JOHNSON	painting labor	$336.00		
DAVIS CONSTRUCTION	contract	$52,453.90		
GRANT CONSTRUCTION	masonary work	$565.00		
TATE CONSTRUCTION	labor	$2,500.00		
BARASH & STOERZBACH	legal	$1,348.00		
MYNATT CONSTRUCTION	handicap rap w/labor	$2,696.00		
ROBERT THOMPSON TRK	black dirt	$350.00		
BARASH & SHOERZBACH	legal	$461.50		
ABC FIRE EXTINGUISHER	sprinkler heads	$57.06		
DIRECT SUPPLY	misc bldg materials	$644.83		
Otho Tate Construction	Labor/Materials	$9,545.00		
BID SHEET RECEIPTS	$50 each	-$300.00		
		$505,989.00	$59,241.00	